# Medical Officer, Dr B

# Registrar in General Practice, Dr C

# Locum in General Practice, Dr D

# An Accident and Medical Clinic

**A Report by the Deputy**

**Health and Disability Commissioner,**

**Tania Thomas**

**(Case 05HDC12308)**

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

## Parties involved

| | |
|---|---|
| Mr A | Consumer (deceased) |
| Mrs A | Complainant/Mr A's wife |
| Dr B | Provider/Medical Officer, The second accident and medical clinic |
| Dr C | Provider/Registrar in General practice, The second accident and medical clinic[1] |
| First accident and medical clinic | Accident and medical clinic |
| Second accident and medical clinic | Accident and medical clinic |
| A city medical centre | Family's city medical centre |
| A rural medical centre | Rural medical centre |
| Dr D | Provider/Locum in general practice, Mr A's city medical centre |
| Dr E | Consumer's general practitioner, Mr A's city medical centre |
| Dr F | Locum in general practice, first accident and medical clinic |
| Dr G | General practitioner, rural medical centre |
| Dr I | Medical Director, the second accident and medical clinic |

## Complaint

On 29 September 2004, the Commissioner received a complaint from Mrs A about the care her late husband received from several doctors working in general practice between 24 December 2003 and 24 January 2004, and from a District Health Board (DHB) between 25 and 28 January 2004.

As the complaint was primarily directed at the DHB, the Commissioner initially focused his enquiry on the DHB's care. This was resolved in September 2005. The Commissioner went on to focus on the care that Mr A received from several doctors working in general practice. After further review of Mrs A's complaint, the following issues were identified for investigation:

- *The adequacy and appropriateness of the care and treatment that Dr B, medical officer, provided to Mr A.*

- *The adequacy and appropriateness of the care and treatment that Dr C, registrar in general practice, provided to Mr A.*

[1] Dr C left the employment of the accident and medical clinic in late October 2006.

- *The adequacy and appropriateness of the care and treatment provided to Mr A by the second accident and medical clinic.*

- *The adequacy and appropriateness of the care and treatment that Dr D, locum in general practice, provided to Mr A.*

An investigation was commenced on 27 January 2006. The investigation has taken over a year to complete owing to the complexity of the matter.

## Information reviewed

Information from:
- Mrs A
- Dr B
- Dr C
- Dr I (Medical Director, the second accident and medical clinic)
- Dr E
- Dr D
- Dr G

Mr A's clinical records from:
- the first accident and medical clinic
- the second accident and medical clinic
- a city medical centre
- a rural medical centre
- a District Health Board - a provincial hospital
- a District Health Board in a larger centre – city hospital

The following responses to my provisional opinion were received:
- Dr B
- Dr D
- Mrs A's mother, on behalf of Mrs A
- Drs C and I

Independent expert advice was provided by Dr Steve Searle, a general practitioner with experience and postgraduate qualifications in Community Emergency Medicine.

## Information gathered during investigation

*Overview*

The family of Mr A received care from Dr E at a city medical centre. Although Mr A, aged 28, regarded Dr E as his family doctor, he only consulted Dr E once on

16 January 2004. According to Dr E, Mr A did not have any existing medical conditions.

Between 24 December 2003 and 24 January 2004, Mr A presented seven times at four different medical centres in two regions for his ongoing sore throat and difficulty with swallowing. On 24 January 2004, following his seventh consultation, Mr A was admitted to a provisional hospital for further investigation, and subsequently was transferred to a city hospital intensive care unit, where he was diagnosed with lymphoma (a malignant tumour of the lymph nodes). Mr A died in this hospital a short time later.

*First consultation on 24 December 2003*
On the evening of 24 December 2003, Mr A experienced epigastric pain (pain in the upper central region of the abdomen) and right-sided chest pain, lower backache with associated fever, and tiredness. As his city medical centre was closed, he sought after-hours medical assistance from the first accident and medical clinic**.**

On arrival at approximately 6.25pm that evening, the receptionist gave Mr A a registration form to complete, which included a section seeking the patient's consent for his consultation notes to be sent to his regular general practitioner. However, Mr A did not complete and sign this portion of the form. Consequently, the clinic was not authorised to forward Mr A's treatment notes, and did not send a copy to Dr E.

At approximately 6.50pm, Mr A had an initial triage assessment with the nurse on duty, who recorded Mr A's symptoms as "fever, pain right-side chest, shortness of breath — worse on inhaling, pain, lower back pain". His baseline observations included a temperature of 38°C, pulse rate of 60bpm and blood pressure of 120/80mmHg.

Mr A was seen on this occasion by Dr F, a locum in general practice, who examined his chest, heart, abdomen and back. There were no unusual clinical presentations, except for the inflammation in Mr A's throat, which Dr F documented as "throat red". He also ordered a urine test and chest X-ray, both of which were normal. Dr F recorded his diagnosis of "? Viral upper respiratory tract infection with muscle pain" and prescribed Voltaren for Mr A's pain. He documented the advice he provided to Mr A regarding warning signs of breathlessness and increased chest pain, which would warrant a self-referral to hospital. Dr F also advised a clinical review the following day if Mr A's pain persisted.

Following this consultation, Mr A did not seek further medical care until January 2004.

*Second consultation on 11 January 2004*
Two and a half weeks later, at approximately 7.22pm on Sunday 11 January 2004, Mr A presented to a second accident and medical clinic. This clinic is an ACC accredited level two accident and medical clinic, open daily between 7.30am and

11pm. It is wholly owned by a private company, and references to the clinic in this report include the private company that owns it.

On arrival, Mr A was given a form to fill in at the reception. In response to the question, "Why have you come to see the doctor today?", Mr A wrote "sore throat, can[not eat] or drink, fever". Mr A also indicated that he had a headache. The form included a section for patients to decline consent for their medical notes to be transferred to their usual general practitioner. Mr A did not complete this section, which meant that the clinic could forward his notes to the city medial centre. However, the clinic did not send a copy of Mr A's notes to Dr E, as Mr A did not provide details of the city medial centre on the form he completed.[2]

Shortly afterwards, Mr A had a triage[3] assessment. The nurse recorded a history of fever with sore throat since that morning. She did not document any baseline observations (temperature, blood pressure, respiratory and pulse rate).

Mr A was seen by Dr B, a medical officer who was one of the two doctors on duty that Sunday evening. Mr A did not inform Dr B of his visit to the first accident and medical clinic on 24 December 2003. Dr B documented Mr A's clinical history as "tired, headache, hard to swallow — drinking OK". On examination, Dr B's findings were "undistressed, big inflamed tonsils with heaps of almost black exudate[4] on medial surfaces". He could not recall whether he considered taking a throat swab during the consultation, and explained that throat swabs were not routinely taken in adults with infected tonsils. In addition, although it is Dr B's practice to examine the neck nodes in presentations such as Mr A's, Dr B could not recall whether the consultation included such an investigation since his clinical notes do not contain any record of a lymph node examination. Dr B diagnosed Mr A with tonsillitis, and prescribed liquid Augmentin (an antibiotic) and liquid paracetamol for Mr A's pain. He did not document any follow-up advice, and could not recall any advice he may have given to Mr A during this consultation. Dr B commented that he would usually advise patients with presentations similar to Mr A's to return to him or see another doctor if there was no improvement in their condition after two to three days.

Dr B described his assessment of Mr A as follows:

> "… I regret that I cannot reliably recall anything more than what is recorded in the clinical notes from that consultation.

[2] Refer to Appendix 1 for a copy of the form Mr A filled in on 11 January 2004.
[3] Triage is a system whereby a group of patients is sorted according to the seriousness of their injuries or illnesses so that treatment priorities can be allocated.
[4] Exudate comprises material such as fluid, cells and cellular debris that has escaped from blood vessels and is deposited in tissues or tissue surfaces, usually as a result of inflammation.

> I would note that there is no mention of back pain in what the patient wrote (Q7) on the [clinic's] enrolment form, in the nurse's triage note, or in my notes. It is possible he did tell me this symptom, and I made no note of it, as it is a common complaint, along with headache and tiredness, from a person suffering from an infection such as tonsillitis.
>
> My assessment may well have been biased by reading the nurse's triage note 'sore throat since this am' suggesting his unwellness had only begun. Certainly, I do not seem to have received any information to that effect that he had recently (24 December 2003) seen a GP elsewhere … therefore, I do not seem to have become aware that he was presenting with anything other than an illness of acute onset."

Dr B commented:

> "In retrospect, it is obvious that I should have done more to ascertain when the tiredness began, and what other symptom (eg. back pain) there might have been.
>
> ...
>
> I wish to apologise to the wife and whanau of the late [Mr A] for my failure to make the correct diagnosis of his condition at the time, or to instigate investigations to that end. I feel I made a serious error of judgement, and was insufficiently astute in not recognising and responding appropriately to the clues that were presented."

*Third consultation on 15 January 2004*

On the morning of 15 January 2004, Mr A returned to the second accident and medical clinic as he still had a sore throat and felt unwell. This was Mr A's third visit to a doctor since 24 December 2003, and his second presentation at this clinic. Mr A had been off work for several days and required an extension of his medical certificate. The triage nurse at the clinic documented "throat still very sore and feels unwell, febrile [feverish]". Has been off work. Med cert ran out yesterday, will require another". The nurse did not document any baseline observations.

Following the nurse's assessment, Mr A was seen by Dr C, who had with him Dr B's clinical notes of 11 January 2004. As Mr A did not inform Dr C that he had consulted a doctor on 24 December 2003, Dr C understood that Mr A's symptoms began on or around 11 January 2004. Mr A did not complain of enlarged glands, back pain or tiredness during the consultation. Based on Dr C's examination of Mr A's throat, neck and lungs, Dr C did not detect any enlarged glands or lymphadenopathy (swelling in the lymph nodes). Dr C documented "History as above (nurse's notes). On examination afebrile [absence of fever], temperature 36.6°C.[5] Throat inflamed, tonsils

[5] The normal body temperature is between 36°C and 37°C. A person has fever when the body temperature rises above 37.2°C.

enlarged. Exudate + No wheeze, lungs clear." As Dr C considered Mr A's clinical presentation similar to that presented to Dr B four days earlier, Dr C also diagnosed Mr A with tonsillitis. In response to Mr A's complaint that he disliked the taste of Augmentin and found it ineffective, Dr C prescribed a different antibiotic in the form of gelatinous penicillin capsules to be taken every six hours for one week. In addition, Dr C advised Mr A to gargle his throat, and wrote a medical certificate for another three days of work absence.

*Fourth consultation on 16 January 2004*
The following day, on the morning of Friday 16 January 2004, Mr A consulted Dr E, his own general practitioner at the city medical centre. This was his first consultation as a patient, although Mr A had accompanied his family on other occasions to see Dr E when they required medical care. It was also Mr A's fourth visit to a doctor since 24 December 2003.

Mr A informed Dr E that his throat had been sore but was improving, and complained of back pain of unknown origin. Mr A also complained of occasional leg pain and coughing with occasional green sputum. Dr E documented a history of five days of throat infection since Sunday 11 January (when Mr A saw Dr B), and noted that Mr A was not prone to back pain.

Based on her examination, Dr E noted that Mr A was afebrile, and did not look unwell. She documented that his throat was slightly red, and there was halitosis (bad breath). Dr E also examined Mr A's back and legs, and noted that he had a normal range of leg movements with normal neurology, no bony spinal tenderness but poor flexion of the spine. Dr E diagnosed a muscular lumbar cause for Mr A's back pain, and prescribed Voltaren. She recommended exercise, and provided him with a form to undergo blood tests. However, following his consultation with Dr E, Mr A did not present at the laboratory for blood tests as he continued feeling unwell.

*Fifth consultation on 19 January 2004*
On the afternoon of 19 January 2004, Mr A returned to the second accident and medical clinic to extend his medical certificate. This was his fifth consultation with a doctor since 24 December 2003, and his third presentation at this clinic. Mr A was not triaged on this occasion as Dr C was available to see him at the time he presented. Although Mr A complained of an ongoing sore throat, he also informed Dr C that he was "getting better". This is confirmed in Dr C's clinical records. Mr A did not inform Dr C that he had consulted Dr E three days earlier, and did not complain of other symptoms such as tiredness or back pain.

On examination, Mr A was afebrile and had an inflamed throat with enlarged tonsils and exudate. Dr C did not detect any enlarged glands or swelling in Mr A's lymph nodes. He did not take a throat swab because Mr A stated that he was feeling better. In addition, Dr C noted that there had not been any increase in Mr A's temperature, which was 35.6°C, compared to the previous reading of 36.6°C on 15 January 2004. Dr C documented that Mr A was re-presenting for a follow-up consultation regarding

his tonsillitis. He also recorded that Mr A was "still having pain. Getting better. Afebrile — 35.6°C. Throat inflamed, tonsils enlarged and exudative. No wheeze." Dr C advised Mr A to continue taking the antibiotics he prescribed on 15 January, gargle his throat with mouthwash and return to his usual general practitioner within two days if there was no improvement in his condition. A medical certificate was provided for another two days of work absence.

In relation to this consultation, Dr C commented:

> "As far as I was aware, [Mr A]'s complaint of sore throat had only been since the morning of 11 January 2004 (as recorded in the clinic's notes). So, when I saw him on 19 January 2004, only eight days had elapsed. It is standard practice to refer patients with similar symptoms for investigations and specialised treatment if they are unresponsive to antibiotic treatment for two weeks. If that were the case with [Mr A], I would have definitely referred him for further investigations and specialised treatment in two weeks or earlier if his condition was worsening."

*Sixth consultation on 22 January 2004*

As Mr A's condition did not improve, he returned to the city medical centre three days later on 22 January 2004. This was his sixth visit to a doctor, and second presentation as a patient at the city medical centre. Mr A was seen on this occasion by Dr D, a locum in general practice who contracts his services to the health centre. Dr D documented Mr A's complaint of a "sore throat [with] difficulty in swallowing, and fever with chills". Mr A did not complain of backache during the consultation. Dr D had access to Dr E's clinical notes of 16 January, and was aware that Mr A had been taking antibiotics since 11 January when he was seen by Dr B.

On examination, Dr D recorded that Mr A's "tonsils [were] grossly inflamed". Although it is not documented in the notes, Dr D clarified during the investigation that it would be his usual practice to examine patients with Mr A's presentation for lymphadenopathy in the neck and to record their temperature. He also clarified that the absence of such record in his notes of 22 January 2004 meant that "both [of] these examinations were normal". Dr D did not consider a throat swab necessary as Mr A was on an existing course of antibiotics, and his clinical presentation did not warrant such an investigation. Since Mr A had not responded well to the existing course of antibiotics, Dr D prescribed Floxapen capsules —— an antibacterial penicillin. He advised Mr A to take Panadol for his sore throat, and provided a medical certificate for a further two days' work absence. Dr D did not document any follow-up advice. He clarified during the investigation that he would advise patients with Mr A's presentation to seek further medical advice if there was no improvement in their condition after several days.

Following this consultation, Mr A continued feeling unwell. On 23 January 2004, Mr A travelled to a rural town to celebrate his nephew's birthday. During the visit, Mr A told his family that he had been unwell. Mr A's sister was concerned to hear

about his ongoing symptoms, and encouraged him to consult a local general practitioner.

*Seventh consultation on 24 January 2004*
Mr A's condition worsened to the point where he had difficulty breathing. On Friday 24 January 2004, an ambulance transported Mr A to a rural medical centre. This was Mr A's seventh visit to a doctor since 24 December 2003. On this occasion, he was seen by Dr G, who observed that Mr A was "very weak — had to be brought in by ambulance". Dr G noted that Mr A's throat, which had been sore for two weeks, was "getting worse". Dr G also recorded that Mr A had presented five times[6] to various doctors in his home city, was unable to swallow his Floxapen and Panadol tablets, and was "not drinking much". He observed that Mr A "looked weak, was speaking OK but [his] voice was hoarse". He also detected severe halitosis (bad breath) which Dr G documented as "halitosis +++".

On examination, Mr A's throat revealed very enlarged tonsils with "necrotising type infection of the left tonsil", and the "tonsils met in the midline"[7]. He had an elevated pulse rate of 136bpm and a fever of 39.2°C. Mr A's oxygen saturation was 93%.[8] Dr G diagnosed a necrotising infection of the tonsils with quinsy (abscess of the tonsils). He referred Mr A to a provincial hospital for intravenous antibiotic treatment.

*Admission to the provincial hospital*
Mr A was transported in his sister's car to the provincial hospital. It is unclear why Mr A was not transferred to hospital by ambulance. At 8.30pm that evening, Mr A was admitted to the Emergency Department. On examination, the surgical registrar observed that he was dehydrated and systematically unwell with fever, hypoxia (reduction of oxygen supply to tissue below physiological levels), hypotension (abnormally low blood pressure) and tachycardia (abnormally rapid heart rate). The size and clinical presentation of Mr A's tonsils were consistent with quinsy. A blood test showed Mr A's creatinine[9] at 0.37mmol/L, which was above the normal range of 0.05–0.12mmol/L. The surgical registrar discussed Mr A's clinical presentation with his consultant and an ENT (Ear, Nose and Throat) specialist at the city hospital. (There were no ENT surgeons on duty at the provincial hospital during the eve of that long weekend.) As the ENT specialist at the city hospital was unable to accept Mr A as an inpatient that evening, he advised transferring Mr A to the Intensive Care Unit (ICU) at the provincial hospital in which he was currently a patient. He also advised administering intravenous fluids and antibiotics, and taking a CT scan of Mr A's pharynx.

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[6] Mr A presented to five different doctors working in general practice in the city, over six (not five) consultations.

[7] The tonsils were so enlarged that they extended from each side to the midline. This has the potential to obstruct the airway and cause breathing difficulties.

[8] The normal oxygen saturation for an adult is between 97–98%.

[9] A waste product of protein metabolism that can be used to measure the overall kidney function. An abnormally elevated blood creatinine level is indicative of kidney failure.

Following this discussion, Emergency Department staff administered intravenous fluids, and attempts were made to drain a suspected abscess in Mr A's throat, but no pus could be drained. At approximately 10pm, Mr A was transferred to the provincial hospital's ICU, and his sepsis (putrefactive destruction of tissues by disease-causing bacteria or their toxins) was treated with intravenous antibiotics. Mr A received calcium chloride, dextrose, insulin, gelofusion, frozen plasma and blood platelets. To stabilise Mr A's airway, he was intubated with fibreoptic nasotracheal lines, which revealed a "huge mass in the nasopharynx (the part of the pharynx that lies above the soft palate) with oedema (excessive accumulation of fluid in the body tissues) of the vocal chords". The ICU consultant queried whether Mr A had lymphoma.

Mr A's condition was discussed with the Director of ICU, at the city hospital, who agreed to admit him for further investigation and management. A decision was made to transfer Mr A by helicopter, and he was airlifted at approximately 1am the next day.

*Transfer to the city hospital*
Two hours later, Mr A arrived at the DHB, and was admitted into its ICU. Later that morning, he was reviewed by three ICU consultants, who recorded a working diagnosis of "suspicious systemic illness and lymphoma", and queried whether Mr A had "superimposed sepsis (infection)". Arrangements were made for an urgent haematology review the following day.

The haematology review took place the next day. In light of the necrotic cells (dead cells) and amount of debris observed in Mr A's bone marrow, the haematologist recommended a diagnostic lymph node biopsy. That afternoon, a biopsy was performed. Two left axillary lymph nodes (lymph nodes in the left armpit area) were dissected and sent for histological review.
The following day, the pathologist made an interim diagnosis of "malignant lymphoma, peripheral T-cell type". His findings were confirmed the next day.

In light of Mr A's extensive tumour and multiorgan dysfunction, chemotherapy was contraindicated. Several meetings were held with Mr A's family to discuss his poor prognosis, and they agreed to change the focus of his care to comfort cares. Mr A died shortly afterwards.

**Other matters**

During the investigation, the second accident and medical clinic was asked for information on its triage procedures, and the process for communicating triage information internally and to the patient's own doctor. The clinic provided the following information.

*Communication of triage information to doctors*
Dr I, Medical Director of the clinic, explained that when patients present to the reception, they are given a registration form to complete. The form includes a self-triage section where patients indicate whether they are presenting with an acute symptom.[10] The system in place at the time Mr A presented in 2004 included the receptionist informing the triage nurse or the doctor of a potential triage alert, and placing the patient's notes in a red folder to highlight the alert. In addition, a patient was also considered a triage alert if the patient or caregiver informed the receptionist that the patient was unwell and unable to complete the registration form.

The clinic's triage policy states that a patient must be assessed within 15 minutes following arrival at the surgery. The triage scale used by the clinic is based on the Australasian College of Emergency Medicine's recommendations. The five levels of acuity (priority for assessment according to the severity of presenting symptoms), corresponding codes and response times for a patient to be seen by a doctor are:

| National/Australian Triage Scale | Treatment Acuity | Numeric Code |
|---|---|---|
| Resuscitation | Seen immediately | 1 |
| Emergency | Seen within 10 minutes | 2 |
| Urgent | Seen within 30 minutes | 3 |
| Semi-urgent | Seen within 1 hour | 4 |
| Non-urgent | Seen within 2 hours | 5 |

If a patient is classified as a triage alert, the duty doctor is informed immediately by direct communication.

In 2005, the clinic implemented an electronic triage system whereby triage alerts are indicated in "red" on the computer, and a "TA" code is assigned next to the patient's name on the triage form.

The clinic's policy was that clinical notes of a casual visit would be transferred to the patient's own doctor only if the patient consented.

*Transfer of patient information to the patient's own doctor*
At the time Mr A received care in 2004, the clinic's policy was that clinical notes of a casual visit would be transferred to the patient's own doctor only if the patient consented. Clinical records were not transferred in instances where the patient refused consent or did not provide details of his or her own doctor.

[10] Refer to section 7 of Appendix 1 for a list of the acute symptoms.

As part of the electronic system implemented in 2005, the clinic now sends a casual patient's clinical notes to his or her own doctor if the doctor's electronic address is stated on the health information database.

## Independent advice to Commissioner

The following expert advice was obtained from Dr Steve Searle:

> "This report has been prepared by Dr S J Searle, under the usual conditions applying to expert reports prepared for the Health and Disability Commissioner. In particular Dr Searle has read the guidelines for Independent Advisors to the Commissioner (Ref. 1)[11] and has agreed to follow them. He has been asked to provide an opinion to the commissioner on case number 05/12308.
>
> He has the following qualifications: MB.ChB (basic medical degree Otago University), DipComEmMed (a post graduate diploma in Community Emergency Medicine — University of Auckland), FRNZCGP (Fellow of the Royal New Zealand College of General Practitioners — specialist qualification in General Practice which in part allows him to practise as a vocationally registered practitioner). As well as the qualifications listed, Dr Searle has a certificate in family planning and a post graduate diploma in sports medicine. He has completed and renewed a course in Advanced Trauma — ATLS (Advanced Trauma Life Support). He has a certificate in Resuscitation to Level 7 of the NZ Resuscitation Council and he has completed a PRIME course. He has worked in several rural hospitals in New Zealand as well as in General Practice and accident and medical clinics and currently works in his own practice as well as in the Emergency Department in Dunedin Hospital and at an after-hours clinic in Dunedin. He is also involved in local search and rescue missions and training.
>
> Dr Searle is not aware of any conflict of interest in this case — in particular he does not know the health provider(s) either in a personal or financial way. Dr Searle has not had a professional connection with the provider(s) to the best of his knowledge.
>
> **Basic Information:**
>
> Patient concerned: [Mr A], at the time a 28-year-old man.
>
> Nature of complaint: The adequacy and appropriateness of the care and treatment from some of the doctors he saw.

[11] See the list of references at the end of Dr Searle's advice.

Complaint about: [Dr B], [Dr C], [Dr D] and [an accident and medical clinic].

Also seen by (but no complaint) [another accident and medical clinic] — [Dr F]; [Dr E], [Dr G], [staff at the provincial hospital].

Also seen by (separate complaint about some aspects of care dealt with separately to this report) [staff and the city hospital].

**Answering Questions put to me by the Commissioner's Office.**

*1) Care and treatment provided by [Dr B] on 11 January 2004*:

*(a) Please comment generally on the standard of care and treatment [Dr B] provided to [Mr A] on 11 January 2004.*
The standard of care was adequate for an apparently straightforward case of a sore throat — a history was taken, an examination made, a diagnosis made and treatment prescribed. Whilst no specific follow-up advice was documented, this is not unusual and is within the normal standard of care for a straightforward case of a sore throat. However given the unusual appearance of the throat a more specific follow-up plan was needed — see (c) and (f) below.

*If not answered above, please comment on the following:*

*(b) The adequacy of [Dr B]'s examination and diagnosis of [Mr A].*
Whilst observations such as temperature and pulse were not made, it is unlikely that they would have changed the management at this point in time and not recording them is within a reasonable standard of care.

*(c) What was the significance of the black exudate [Mr A] presented with?*
[Dr B] noted an 'almost black exudate'. This could have been a slightly unusual appearance of a grey exudate that can occur with glandular fever (Ref. 3) — although with glandular fever, this is more usually yellow (Ref. 4). Usually black appearances are typical of some sort of tissue death — which in this case may have meant a more severe than usual throat inflammation. A truly black appearance would be considered unusual and is rarely seen — a group of my colleagues considered this probably would warrant either closer follow-up or consideration of a referral to hospital (Ref. 2). I also discussed this particular issue with a locum (Ref. 5) and they considered if it was an appearance they had not seen before they would have at least phoned an Ear Nose and Throat specialist to discuss the case — or alternatively referred them to hospital for such an opinion. I note none of the doctors who subsequently saw [Mr A] commented on this and I would assume the appearance had either resolved, or partly resolved, to the point where the appearance was not that unusual. I note in [Dr B]'s letter of 5/2/06 that '… this should have set off some "alarm

bells" in my mind that they were not simply infected tonsils.' I think that a range of responses to seeing the appearance of blackness of some sort could have included organising some blood tests and some definite follow-up, or at least strictly advising the patient to see a doctor within two to three days for review and sooner if he was worse or developing new symptoms. Further examination such as lymph nodes (both in the neck and elsewhere), checking for an enlarged spleen or liver and checking observations such as pulse, temperature, and weight could have been useful for future comparison. Referring him to hospital may not necessarily have been accepted or changed the management at this point. Whilst I and my colleagues do not have a firm opinion on which combination of the above extra steps in the management of [Mr A] was strictly needed, there was general agreement that some combination of the above measures was needed along with a more specific follow-up plan.

*Please comment on the appropriateness of [Dr B]'s assessment of this symptom.*
Technically, this is a 'sign' (the appearance of a black exudate) rather than a symptom (something the patient complains of). As above the significance is the possibility of something more severe happening. The assessment and overall management was therefore as above not sufficient. **I would view this departure from the standard of care with mild disapproval and I note [Dr B] already has acknowledged with hindsight that 'alarm bells' should have alerted him.**

(d) *Are there any additional investigations/examination that [Dr B] should have carried out for the symptoms [Mr A] presented?*
This has already been commented on above. There is much debate about the need to 'swab' throats or not (Ref. 4), and I note it is not even mentioned in one emergency medicine text with the approach being to treat and send home, or to treat and admit (Ref. 3).

*(e) Did [Dr B] prescribe appropriate medication?*
Generally speaking, a narrow spectrum penicillin is used, although a wider spectrum penicillin can be used (such as the Augmentin used here). Usually the treatment is for ten days (Ref. 4). However there is much debate about both the exact treatment and duration for this condition. Such debate is beyond the scope of this report. In short, the medication prescribed was within a usual standard of care.

*(f) Was [Dr B's] documentation of an adequate standard?*
The documentation was within a usual standard for a typical sore throat case. However given my comments above about the exudate then a more specific follow-up plan should have been made and documented.

2 *Care and treatment provided by [Dr C] on 15 January 2004:*

*(a) Please comment generally on the standard of care and treatment [Dr C] provided to [Mr A] on 15 January 2004.*
I think the standard of care and treatment was adequate.

*If not answered above, please comment on the following:*

*(b) The adequacy of [Dr C]'s examination and diagnosis of [Mr A].*
I think the standard of care concerning these aspects of the case management was adequate.

*(c) Should [Dr C] have taken a throat swab?*
This is under much debate for sore throats and discussion of this in any detail is beyond the scope of this report. The debate about this has been around for some time (Ref. 4), and sometimes taking a throat swab is not even considered (Ref. 3). My colleagues (Ref. 2) would not always take a throat swab and most would not have in this case. Thus the short answer is no.

*(d) Was it appropriate for [Dr C] to advise [Mr A] to discontinue taking the Augmentin syrup?*
This is reasonable if there is a reason — although not in the notes as documented, I note that [Dr C] in his letter 13/2/06 states that '… he disliked the taste …'. This is a reasonable reason to stop the Augmentin.[12]

*(e) Did [Dr C] prescribe appropriate medication?*
The penicillin prescribed is an appropriate treatment — I also note he prescribed this for a week which combined with the treatment he had already had, makes a total of 10 days treatment which is generally considered a good thing for bacterial sore throats (Ref. 4).

*(f) Was [Dr C]'s documentation of an adequate standard?*
Yes, the documentation was typical of the usual standard of documentation for this sort of condition.

3) *Care and treatment provided by [Dr C] on 19 January 2004:*

(a) *Please comment generally on the standard of care and treatment [Dr C] provided to [Mr A] on 19 January 2004.*

[12] Dr Searle clarified that taste is an individual matter. Accordingly, it would be reasonable to substitute a prescription with a similar alternative to prevent a situation where the patient stops taking the medicine because of his/her aversion to its taste.

As stated in the notes made at the time, [Mr A] was apparently feeling as though he was getting better. Given his main purpose was to obtain an extension of a medical certificate, it was a good standard of care that he was re-examined — both his throat and temperature. It was also good that he was advised to see his GP in two days' time if he was not getting better. Whilst it could be argued that needing another work note was a sign he was not entirely better, I think given he considered he was improving and his examination did not show anything to suggest otherwise, that this along with the advice to be seen in a further two days' time if he was not getting better was a very reasonable standard of care.

*If not answered above, please comment on the following:*

*(a) The adequacy of [Dr C]'s examination and diagnosis of [Mr A].*
Given he was apparently getting better as above the examination and diagnosis was adequate.

*(b) Should [Dr C] have taken a throat swab?*
As per 2(c) above no. This would especially be the case given he was improving.

*(c) Are there any further investigations that [Dr C] should have undertaken?*
[No,] not given that he was apparently improving.

*(d) Was [Dr C]'s advice to continue with the antibiotics appropriate?*
Yes it is important to finish the course of most antibiotics.

(*g) Was [Dr C]'s documentation of an appropriate standard?*
The documentation was of an appropriate standard and did document the follow-up advice.

*4) [The second accident and medical clinic]*

*(a) Please comment generally on the standard of care and treatment that the Clinic provided to [Mr A] from 11–19 January 2004.*

*If not covered above, please comment on the following:*

*Did the Clinic have adequate triage procedures in January 2004?*
First, we should consider if triage procedures are needed at all. This is not a simple topic and I enclose a separate report on triage[13] as to include all the comments I have on the topic of triage here would

[13] See Appendix 2.

detract from other parts of this report. In brief, I would say that there was no need to have triage procedures and thus to ask if they were adequate is not really meaningful. Even if triage was thought to be needed, there is much debate about how to do this — see my separate report. Of further note unless a patient was extremely unwell, for example severely dehydrated or generally unwell with a sore throat it is unlikely that any triage system would classify his case as more 'urgent'. Even if classified as more 'urgent' on a triage basis this would not necessarily have changed the way a doctor would have looked at a case of a sore throat.

*(b) If the triage procedures were not adequate, what procedures should have been in place?*

As per (b) above, there is no good evidence for triage and much debate on what triage, if any, should occur. To decide if the triage was adequate really requires knowledge of the types and numbers of patients presenting to the clinic, the staffing and facilities available and a knowledge of other health facilities in the area that may either refer patients to the clinic and/or take referral of patients from the clinic, along with knowledge of local geography etc. This is all beyond the scope of this report and my comments on the adequacy or not of triage could be misleading if they were based solely on the information I have available — thus I can not comment in any meaningful way on the adequacy of triage procedures at this particular clinic.

*(c) Was [Mr A] properly triaged for assessment by a doctor when he presented on 11 and 15 January 2004?*

He certainly needed to see a doctor so yes it was proper for him to be triaged for assessment by a doctor — although it would be rather unusual to triage someone to not see a doctor except in a case where there was disaster and all the available doctors were tied up seeing seriously ill patients from the disaster. It would not have been proper for him to have been solely seen by someone other than a doctor such as say a nurse alone. Commenting on other aspects of triage such as how quickly he should have been seen after triage, or as to if he should have been triaged at all (and not simply just seen a doctor after waiting in turn) is not straightforward as per (b) and (c) above — however I do not think there was any need for him to be seen urgently (say within minutes) although clearly he needed to be seen each time he presented. It should of course be noted that how quickly someone needs to be seen according to any triage system does not always agree with the overall seriousness of their condition or their final need or type of treatment, and it does not always agree with their need to be sent to hospital or not.

(d) *Was the Clinic's system for transferring triage information and medical records satisfactory?*

I will divide this into two parts — one; transferring information within the centre, and two; transferring information back to the general practitioner.

Transferring information back to the GP (general practitioner)

In general, this is important and there is good evidence that continuity of care improves outcomes. I am not aware of any research having been done on how best to encourage patients to allow their information to be sent back to GPs — however from my experience, working at accident and medical clinics and emergency departments, of those patients who initially have apparently declined to have their notes sent to their GP it is usually because of oversight and/or misunderstanding of the form they filled out and occasionally because they thought it was not worth bothering their GP about the minor problem. Mostly, if I personally ask these patients about sending notes on to the GP they almost all agree. I find the best time to ask about this is at the time I give follow-up advice — usually stating they should see their GP if they are not 100% by the time I expect the illness or condition to have fully resolved, or in a few days if not improving or back to the GP or another doctor sooner if they are worse or have new symptoms. I usually then check we have their GP correct on the form or prompt the patient about who their GP is if they have left this blank or apparently declined to have notes sent to the GP.

I note that [the clinic] has a receptionist procedure for faxing notes to GPs. This seems to be a reasonable set of measures. However, I would see the transferring of notes back to the GP to be such an important issue that other staff such as the nurses and doctors should be involved. I think that where the patient has declined to nominate a GP, the doctor seeing them should check on this and note they have done so. I note that in the 'Alteration: Faxing notes to GP protocol' that Nursing medical staff are included.

(e) *Please advise on the adequacy of the steps the Clinic has taken in light of this incident.*

I note that in the 'Alteration: Faxing notes to GP protocol' that Nursing medical staff are included. I suspect that in order to get this to actually happen will require some other measure such as the doctor initialling beside where it states the notes should or should not go back to the GP — in other words it is one thing to have a protocol or policy, it is another to see it actually implemented — they may need to audit this or arrange some other method of checking that medical and nursing staff are actually paying attention to this matter — it may be worth integrating this with a check on the adequacy of documentation of

follow-up advice which can be critical in avoiding errors and improving standards of care.

I am not sure in this case that having the notes sent back to the GP would have made a difference — it may or may not have (given that GP was aware that he was already being treated I suspect it would not have). However, regardless of [whether] an outcome would have changed or not, it is important to maintain good standards of care — there is clear evidence that continuity of care gives better outcomes and in general, a good standard of care is to send copies of notes to a patient's GP.

5. *Care and treatment provided by [Dr D] on 22 January 2004:*

(a) *Please comment generally on the standard of care and treatment [Dr D] provided to [Mr A] on 22 January 2004.*
It is clear at the time of consultation that Dr D had a patient who was not improving and who had been unwell for at least ten days ([Dr E]'s notes from 16/1/4 were available at the time and stated that he had 'throat infection since Sun' — [Dr D] also confirms having these notes and being aware of their content in his letter 19/2/06.

Thus, we have a 28-year-old man who has not improved and complaining of fever and chills despite at least ten days of treatment. In this situation he either needed admission to hospital, or close follow-up by the GP or locum which would have had to include getting blood tests that day and getting told the result of these tests the same day. **My colleagues (Ref. 2, 5) and myself all consider that the standard of care was inadequate and viewed with at least mild and mostly moderate disapproval of the failure to recognise the significance of a patient who was not getting better and to arrange more specific follow-up.**

*If not covered above, please comment on the following:*

(b) *The adequacy of [Dr D]'s examination and diagnosis of [Mr A].*
Most of my colleagues would have examined [Mr A] further at this stage including pulse and temperature, and nodes, and chest and abdomen. Some would have even checked a urine sample. However regardless of these findings, all felt the history of a man with ten or more days of treated throat infection who was still having fevers and chills and a persisting sore throat warranted either immediate same day referral or same day follow-up. They would have at least enquired as to if the blood test (that [Dr E] had requested) had been done and if so followed up the result.

*(c) Are there any additional investigations/examination that [Dr D] should have carried out?*
As above, either referral to hospital or closer follow-up was required including blood tests.

*(d) What follow-up should [Dr D] have provided in relation to the symptoms [Mr A] presented to [Dr E] on 16 January 2004?*
As above, either referral to hospital or closer follow-up was required including blood tests.

*(e) Was [Dr D]'s decision not to take a throat swab appropriate?*
As stated elsewhere in this report the use of throat swabs is debatable. Not taking one was acceptable.

*(f) Was it appropriate for [Dr D] to prescribe Floxapen?*
Although the drug data sheet states that it can be used for tonsillitis and quinsy, it was noted by my colleagues that this is not usually a drug used in this condition as normally plain penicillin is adequate. Usually, Floxapen (flucloxacillin) is reserved for staphylococcal infections. Certainly, I have occasionally prescribed flucloxacillin for a sore throat but only when there was another illness that I thought was due to a staphylococcal infection elsewhere on the body. Changing the antibiotic was not considered to be a substitute to adequate close follow up or referral which is really what was needed in this situation as stated above.

*(g) Was [Dr D]'s documentation of an appropriate standard?*
My colleagues (Ref. 2, 5) and myself all considered that even 'normal' examination findings should have been documented in this situation where [Mr A] was not getting better. I note that [Dr D] states in his letter of 19/2/06 that his lack of documentation means that the things he normally examines (nodes and temperature) were normal — this however is not of much help to any subsequent doctor who might have had to see [Mr A] as they would not necessarily know what [Dr D] normally examines or not. **The documentation was not of an appropriate standard as all the examination findings (even the normal ones) and specific follow-up plans should have been documented in this situation. This poor documentation I view with mild disapproval.**

**Conclusion:**
Whilst in this case there was more happening than what might have seemed to be a simple case of a sore throat, it is difficult to say at what point in time this could have been picked up on. I think it is important for doctors to consider more serious underlying disorders (Ref. 4) — maybe not necessarily at first presentations but certainly with unusual or repeat presentations. Doctors in

general should be reminded of this. Also doctors should be aware that if something is unusual, such as the possible black appearance of a throat, that they should trust their instincts (or be alert to the situation being unusual) and do something about it. Also, if patients are not improving as expected it is important to reconsider the diagnosis and treatment and also consider the possibility that some other condition may also be happening that could be even more important to sort out than the obvious problem.

**References:**

1) Statements about Health and Disability decisions: One of the principles of giving advice to the Health and Disability Commissioner is that the 'outcome of the care is irrelevant' — it may be that there was no departure from the accepted standards, but the care still resulted in an adverse outcome for the consumer. Conversely, there may have been no adverse outcome for the consumer, but the care may have been substandard. (This statement is also contained in Guidelines for Independent Advisors; effective date 9 November 2005.)

2) Discussion of the case (with patient and doctor details removed) with a group of 6 other colleagues (General Practitioners). Two of these colleagues have recently been locums (they were working as locums at the time of the events in this particular case). To try and clarify an opinion mainly about the consultation of 22 January 2004, they were given the notes from that day, plus the notes from 16 January 2004 (which were available at the time of the consultation on 22 January 2004). Only after full discussion of the case based on the apparent facts available on 22 January 2004, were they subsequently asked about the significance of a black exudate in a throat.

3) Accident and Emergency — Diagnosis and Management; 4th edition, Anthony F.T. Brown, 2002, ISBN 0 340 80720 2.

4) General Practice, John Murtagh, McGraw Hill, 1994.

5) Discussion of the case (with patient and doctor details removed) with a currently practising locum. Information was presented to try and clarify an opinion mainly about the consultation of 22 January 2004. They were given the notes from that day plus the notes from 16 January 2004 (which were available at the time of the consultation on 22 January 2004). Only after full discussion of the case based on the apparent facts available on 22 January 2004, were they subsequently asked about the significance of a black exudate in a throat.

## Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

*RIGHT 4*
*Right to Services of an Appropriate Standard*

*(1) Every consumer has the right to have services provided with reasonable care and skill.*

*(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

## Relevant standards

The Medical Council of New Zealand's publication *Good Medical Practice — A Guide for Doctors* (2003) states that doctors must:

> "keep clear, accurate, and contemporaneous patient records that report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed".

## Opinion

This report is the opinion of Tania Thomas, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

## Breach — Dr B

*Care and treatment*
Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that patients have the right to have services provided with reasonable care and skill. On 11 January 2004, Mr A consulted Dr B regarding his fever, persistent sore throat, and difficulty in swallowing. This was his second consultation with a doctor following his initial visit to the first accident and medical clinic on 24 December 2003, and Mr A's first presentation at the second accident and medical clinic.

Had the consultation been for a straightforward case of sore throat, my independent general practice advisor, Dr Steve Searle, would have considered Dr B's standard of

care adequate. However, Mr A presented with an "almost black exudate", which indicated that there was something more severe than the usual throat inflammation, since black appearances are typical of some form of tissue death. According to Dr Searle, Dr B should have investigated this clinical sign further by taking a combination of measures including organising blood tests, examining Mr A's lymph nodes in the neck and elsewhere, and checking for an enlarged spleen or liver. In addition, given that the clinical appearance of Mr A's throat was somewhat unusual, Dr Searle advised that it would have been prudent for Dr B to have discussed his observations with an Ear, Nose and Throat specialist. Dr Searle commented that there is much debate amongst doctors about taking a throat swab for complaints of a sore throat, and he did not consider that this investigation was necessary during the consultation on 11 January 2004. He noted that Dr B did not document Mr A's baseline observations in his clinical records, and commented that it could have been useful to compare Mr A's temperature, weight, and pulse reading with readings at future consultations. However, Dr Searle advised that the absence of such record was within a reasonable standard of care since it is unlikely that the information would have changed Dr B's management of Mr A's care at this point. I accept Dr Searle's advice and acknowledge that in addition to the tight time constraints that general practitioners face in conducting a consultation, Dr B was seeing Mr A for the first time and was unfamiliar with his medical condition apart from the information that Mr A provided.

Along with the need for further investigation, Dr Searle advised that Dr B should have devised a more specific follow-up plan (discussed below). Although it would have been prudent for Dr B to have discussed the option of a public hospital referral, Dr Searle noted that Mr A may not necessarily have been accepted into secondary care following this consultation given that the public hospital may not have regarded his condition as sufficiently serious. Even if Mr A had been admitted as a hospital inpatient at this stage, Dr Searle commented that it may not have altered the management of Mr A's care. I note Dr Searle's advice that it was appropriate for Dr B to prescribe Augmentin (a wider spectrum penicillin) in response to his diagnosis of tonsillitis.

Taking into account Dr Searle's advice, my view is that Dr B's care on 11 January 2004 was satisfactory in some respects, although he should have initiated further investigations, and devised a more specific follow-up plan. In light of these omissions, Dr B breached Right 4(1) of the Code, and the deficiencies in his care would be viewed with mild disapproval by his peers. I note that Dr B has acknowledged with hindsight that "alarm bells" should have alerted him during the consultation.

## Adverse comment — Dr B

*Documentation*
Right 4(2) of the Code states that patients have the right to have services that comply with relevant legal, professional, ethical and other standards. This includes the responsibility on providers to adequately document their consultations, since accurate documentation and record-keeping form a fundamental part of good quality care.

Dr Searle advised that he would have considered Dr B's standard of documentation adequate had Mr A presented with a typical sore throat. However, as discussed above, the appearance of "almost black exudate" suggests that Mr A had more than a common throat inflammation. Accordingly, Dr Searle advised that Dr B should have formulated a more specific follow-up plan documenting his advice to seek further medical review within two to three days or sooner if Mr A's condition worsened or if new symptoms developed. Although I do not consider that Dr B breached Right 4(2) of the Code in relation to his standard of documentation, I share Dr Searle's view, and have drawn Dr B's attention to my advisor's comments.

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## Opinion: No Breach — Dr C

*Care and treatment*
Mr A presented twice to Dr C: on 15 January 2004 for his ongoing symptom of a sore throat despite taking antibiotics for four days, and on 19 January 2004 when he continued to be troubled by his sore throat, but stated that he was getting better. On both visits, Mr A sought an extension of his medical certificate.

Care and treatment on 15 January 2004
Dr C provided Mr A with an appropriate standard of care on 15 January 2004. This was Mr A's third consultation with a doctor since 24 December 2003, and his second presentation at the second accident and medical clinic. On examination, Dr C noted that Mr A was afebrile with a temperature of 36.6°C. Although he had an inflamed throat with enlarged tonsils and exudate, Dr C did not detect any enlarged glands or swelling in Mr A's lymph nodes. Accordingly, it was not necessary for Dr C to take a throat swab during this consultation. I am satisfied that Mr A was adequately examined, and it was reasonable for Dr C to make a diagnosis of exudative tonsillitis based on Mr A's clinical presentation. In addition, Dr Searle advised that it was appropriate for Dr C to advise Mr A to discontinue Dr B's prescription of Augmentin syrup in light of Mr A's aversion to its taste, and to prescribe penicillin as an alternative to treating a bacterial sore throat. Given that a patient may have preferences for certain tastes, Dr Searle advised that it is reasonable for a doctor to substitute a prescription with another suitable alternative to avoid a situation where the patient refuses to take the prescription because of his or her aversion to its taste.

In summary, my view is that Dr C's care and treatment on 15 January 2004 was satisfactory, and did not breach Right 4(1) of the Code.

Care and treatment on 19 January 2004

Dr Searle advised that Dr C provided Mr A with an appropriate standard of care when he re-presented on 19 January 2004. This was Mr A's fifth consultation with a doctor, and his third visit to the second accident and medical centre. Mr A stated that he was "getting better" and the purpose of his visit was to seek an extension of his medical certificate. In that respect, it was prudent for Dr C to verify Mr A's comment by taking his temperature and re-examining his throat. Dr C noted that Mr A was afebrile (35.6°C) and had an inflamed throat with enlarged tonsils and exudate. His clinical findings were similar to that of his earlier findings on 15 January 2004, and consistent with Mr A's comment that he was improving. I accept Dr Searle's comment that it was not necessary to take a throat swab, and that Mr A was adequately examined during the consultation. It was also prudent for Dr C to advise Mr A to continue taking his penicillin prescription, and to return to his own doctor in two days' time if his condition did not improve.

Taking into account all of these factors, I conclude that Dr C's care of Mr A on 19 January 2004 was satisfactory, and did not breach Right 4(1) of the Code.

*Documentation*

I accept Dr Searle's advice that Dr C's standard of documentation for both consultations on 15 and 19 January 2004 was of an appropriate standard. In my view, Dr C did not breach Right 4(2) of the Code in relation to his record-keeping.

## Opinion: No breach — The accident and medical clinic

*Care and treatment*

Mr A presented at the second accident and medical clinic on three occasions: 11, 15 and 19 January 2004. He was triaged for assessment by a doctor on 11 and 15 January 2004, but not triaged on 19 January 2004 as a doctor was available to see him on his arrival. I accept Dr Searle's advice that Mr A was appropriately triaged on 11 and 15 January. Although he needed to be seen by a doctor at each of the three visits, Dr Searle commented that Mr A's condition was not acute, and did not warrant an urgent/immediate medical review. I also note Dr Searle's comment that even if Mr A had been triaged as "urgent", it would not necessarily have changed the way a doctor would have looked at his complaint of a sore throat. Accordingly, in my opinion, the accident and medical clinic did not breach Right 4(1) of the Code in relation to its care and treatment of Mr A on 11, 15 and 19 January 2004.

*Transfer of triage information*

Dr Searle commented that, in general, it is important for an accident and medical clinic to transfer a casual patient's clinical records back to his or her own general practitioner. Doing so ensures continuity of care, which in turn contributes towards improving the patient's overall clinical outcome.

At the time Mr A presented, the accident and medical clinic had in place a procedure for its receptionist to fax a patient's clinical records back to the patient's own doctor, which Dr Searle considered satisfactory. In addition, Dr Searle advised the need for nursing and medical staff to be involved in this procedure given the importance of transferring a patient's information to his or her own doctor. Dr Searle also advised that in situations where a casual patient does not provide the details of his or her own doctor, it would be prudent for the doctor attending to the patient to ask for that information, and to document the request. In addition, it would also be prudent as a check for the doctor to initial beside his or her notes whether a patient's records should/should not be sent to the patient's doctor. Although it would have been advisable for the accident and medical clinic to have taken these additional measures, I accept that Mr A's outcome would probably not have differed even if the accident and medical clinic had sent a copy of his notes to Dr E, since she was aware that he had been seeing other doctors as a casual patient prior to his consultation with her on 16 January 2004.

In summary, I am satisfied with the accident and medical clinic's process for transferring triage information and medical records internally and back to the patient's own doctor. Therefore, in my view, the accident and medical clinic did not breach Right 4(2) of the Code. I also note that, since 2005, the accident and medical clinic has moved from a paper-based system to an electronic system for transferring patients' clinical records between doctors.

*Vicarious liability*

In addition to any direct liability for a breach of the Code, an employing authority may be vicariously liable under section 72(3) of the Health and Disability Commissioner Act 1994 (the Act) for any breach of the Code by an agent, or under section 72(4) for any breach of the Code by a person as a member of an employing authority. Under section 72(5) of the Act, it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the act or omission leading to an employee's breach of the Code.

Dr B was contracting his services to the accident and medical clinic at the time of the events in question, and his care and treatment on 11 January 2004 breached Right 4(1) of the Code. However, I am satisfied that Dr B's breach was an independent clinical decision, and not one that an employing authority could have prevented. Accordingly, in my view, the accident and medical clinic is not vicariously liable for Dr B's breach of the Code.

## Opinion: Breach — Dr D

*Care and treatment*
Mr A's visit on 22 January 2004 was his sixth presentation to a doctor since 24 December 2003, and his second visit to his city medical centre. Dr Searle advised that Dr D's standard of care on this occasion did not reach an acceptable standard. Since Dr D had access to Dr E's clinical records of 16 January 2004, it was clear to Dr D that Mr A had been unwell for over a week, and was not improving despite receiving treatment from several doctors. In that situation, Dr Searle advised that Mr A should either have received a closer follow-up from Dr D or been referred to secondary care.

I agree with Dr Searle that it was imprudent for Dr D not to investigate Mr A's complaint of fever, chills and a persistent sore throat by checking baseline observations such as temperature and pulse rate, and examining Mr A's lymph nodes, chest and abdomen. Although Dr Searle considered it reasonable for Dr D not to take a throat swab during the consultation, it was imprudent that he did not follow up with Mr A on the blood test that Dr E requested on 16 January 2004. In response to Mr A's clinical presentation, Dr D prescribed Floxapen — an antibiotic covering a (slightly) different spectrum of activity compared to the broad-spectrum Augmentin that Dr B prescribed on 11 January 2004, and Dr C's prescription of penicillin on 15 January 2004. Dr Searle advised that Floxapen is usually reserved for staphylococcal infections elsewhere on the body, and plain penicillin would have been adequate in this instance. Dr Searle also commented that it was inappropriate for Dr D to prescribe a stronger antibiotic as a substitute for close follow-up or a referral to a public hospital.

I accept Dr Searle's advice, and note that in a number of respects, the care and treatment Dr D provided on 22 January 2004 was inadequate. Accordingly, in my view, Dr D breached Right 4(1) of the Code, and the deficiencies in his standard of care would be viewed with mild to moderate disapproval by his peers. Dr D has accepted my findings, and confirmed that he has since reviewed aspects of his practice (including his record-keeping — discussed below) that were found wanting.

*Documentation*
Dr Searle advised that Dr D's standard of documentation did not meet an appropriate standard for general practitioners. Dr D explained that he did not document the findings from his clinical examination of Mr A as he considered them "normal". However, this was an imprudent decision given that Mr A was not improving despite having seen several doctors. In addition, the omission of such vital information leaves future doctors unclear about any examination that Dr D may have conducted during the consultation, and the follow-up care and treatment required.

When a patient receives care from several doctors, it is particularly important that the documentation is as clear and comprehensive as possible. Good records help ensure quality and continuity of care, which is a patient's right, affirmed by Right 4(5) of the Code.

In my view, Dr D's record-keeping did not comply with professional standards and breached Right 4(2) of the Code. I accept Dr Searle's advice that the deficiency in Dr D's record-keeping would be regarded with mild disapproval by his peers.

## Actions taken

*Dr B*
During the investigation, Dr B supplied information to this Office that included a written apology to Mrs A and other whanau of the late Mr A. I commend Dr B on his prompt and unreserved admission of responsibility.

Dr B has reviewed his practice in light of my report.

*Dr D*
In response to my provisional opinion, Dr D provided a written apology for his breaches of Rights 4(1) and 4(2) of the Code, and confirmed that he has reviewed his practice.

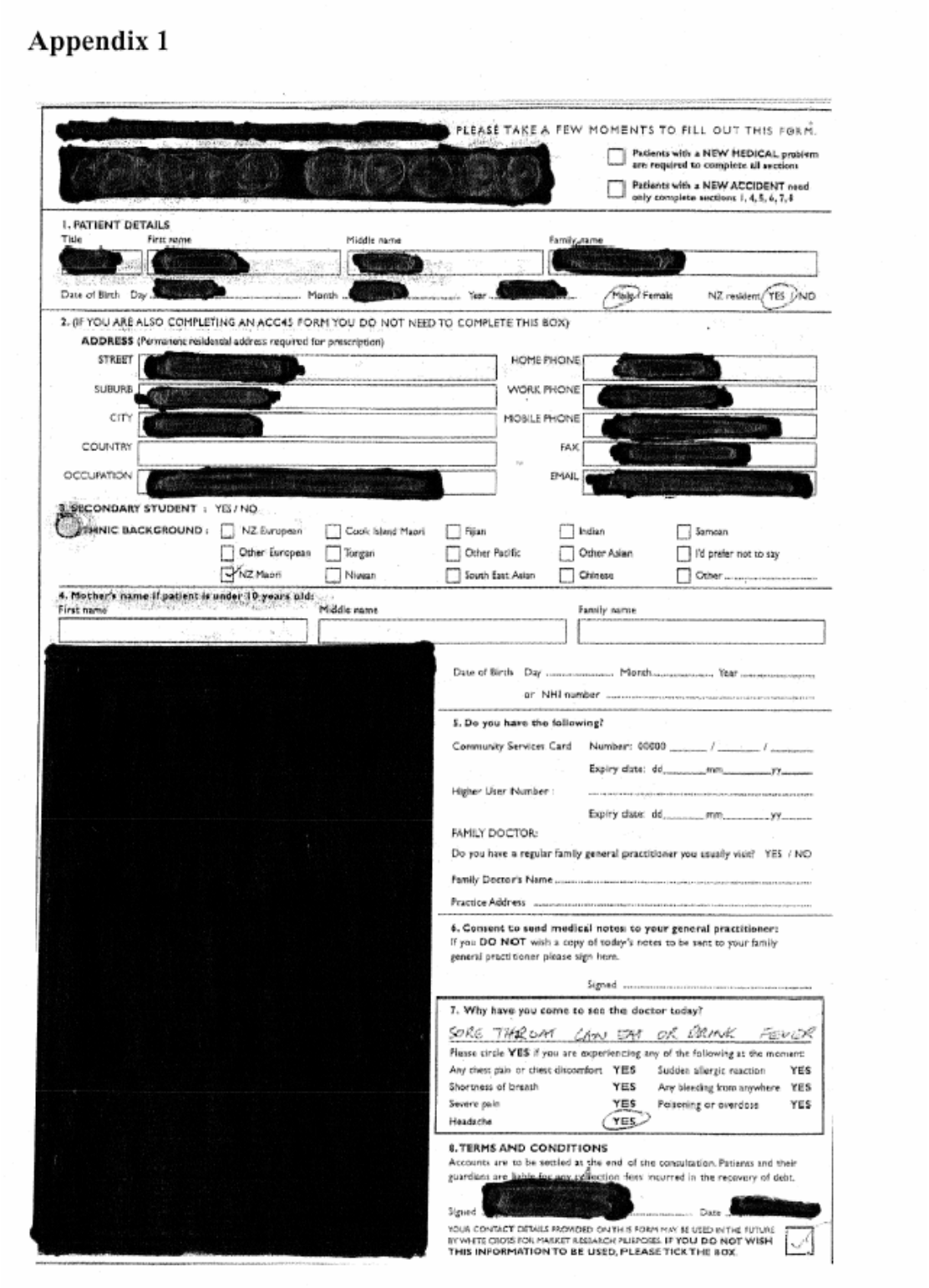
## Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.

- A copy of this report with details identifying the parties removed, except the names of Dr B, Dr C and Dr D, will be sent to the Royal New Zealand College of General Practitioners.

- A copy of this report, with details identifying the parties removed, will be sent to the New Zealand Accident and Medical Practitioners Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

# Appendix 1



Appendix 1

[redacted]

PLEASE TAKE A FEW MOMENTS TO FILL OUT THIS FORM.

☐ Patients with a NEW MEDICAL problem are required to complete all sections

☐ Patients with a NEW ACCIDENT need only complete sections 1, 4, 5, 6, 7, 8

1. PATIENT DETAILS

Title | First name | Middle name | Family name

Date of Birth Day ... Month ... Year ... Male / Female NZ resident YES / NO

2. (IF YOU ARE ALSO COMPLETING AN ACC45 FORM YOU DO NOT NEED TO COMPLETE THIS BOX)

ADDRESS (Permanent residential address required for prescription)

STREET | HOME PHONE

SUBURB | WORK PHONE

CITY | MOBILE PHONE

COUNTRY | FAX

OCCUPATION | EMAIL

3. SECONDARY STUDENT : YES / NO

ETHNIC BACKGROUND : ☐ NZ European ☐ Cook Island Maori ☐ Fijian ☐ Indian ☐ Samoan ☐ Other European ☐ Tongan ☐ Other Pacific ☐ Other Asian ☐ I'd prefer not to say ☑ NZ Maori ☐ Niuean ☐ South East Asian ☐ Chinese ☐ Other ...

4. Mother's name if patient is under 10 years old:

First name | Middle name | Family name

Date of Birth Day ... Month ... Year ...

or NHI number ...

5. Do you have the following?

Community Services Card Number: 00000 ... Expiry date: dd... mm... yy...

Higher User Number : ... Expiry date: dd... mm... yy...

FAMILY DOCTOR:

Do you have a regular family general practitioner you usually visit? YES / NO

Family Doctor's Name ...

Practice Address ...

6. Consent to send medical notes to your general practitioner:

If you DO NOT wish a copy of today's notes to be sent to your family general practitioner please sign here.

Signed ...

7. Why have you come to see the doctor today?

SORE THROAT CAN EAT OR DRINK FEVER

Please circle YES if you are experiencing any of the following at the moment:

| | | | |
|---|---|---|---|
| Any chest pain or chest discomfort | YES | Sudden allergic reaction | YES |
| Shortness of breath | YES | Any bleeding from anywhere | YES |
| Severe pain | YES | Poisoning or overdose | YES |
| Headache | YES | | |

8. TERMS AND CONDITIONS

Accounts are to be settled at the end of the consultation. Patients and their guardians are liable for any collection fees incurred in the recovery of debt.

Signed [redacted] Date [redacted]

YOUR CONTACT DETAILS PROVIDED ON THIS FORM MAY BE USED IN THE FUTURE BY WHITE CROSS FOR MARKET RESEARCH PURPOSES. IF YOU DO NOT WISH THIS INFORMATION TO BE USED, PLEASE TICK THE BOX. ☑



*Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

# Appendix 2

**Sorting out what to do — when & where and the concept of triage**

Sorting out if a person should been seen, and how quickly a person should be seen, for a particular problem and by whom (e.g. ambulance officer, doctors of various types, nurse of various types), and at what location (e.g. GP surgery, Accident and medical clinic, or a hospital emergency department, or some other option), is not as straightforward an issue as it might at first seem. The first decision for any given illness/injury or health problem is usually made by the patient themselves or their friend(s) or relatives. The next step may be to go to a health provider at some point in time convenient to the patient within the perceived necessary time period (in other words a decision has already been made, prior to any health professional being involved, about how urgent the problem is and how soon they should seek attention). At this stage, they may even have decided to call an ambulance. If there is doubt, they may choose to phone a doctor or nurse or a service such as "Healthline" (Ref. 6) in order to help with their decision.

In fact, simply rushing to the doctor early in the course of an illness may be unhelpful — it is well recognised that earlier symptoms of some illnesses (for example meningitis) can be like many other illnesses such as viral flu like illnesses. Seeing the doctor earlier will result in symptomatic treatment and advice on what to watch for in case a more serious illness does develop — it may be that patients already have this knowledge, and may prefer to wait and see doctors at a later point in time. There are various risks of course, such as waiting too long, and certainly if there is doubt patients should see a doctor sooner rather than later. However, sometimes if they are told at a particular point in time when they are seen, that there does not appear to be a serious complication, they may be falsely reassured. Despite advice being given to return should things get worse, or change for various reasons, they may not want to return or they may delay going back to the same or another doctor for another consultation. Even if patients return, there can be complicated issues and processes when patients are seen once or several times in the course of an illness. Preferably, they are seen at the right time and in the right place by the right health professional. Sometimes, there is an overlap between different health professions and facilities. This overlap is probably a good thing so that patients don't fall into the gaps. Many illnesses are seen either at an Emergency Department, or a GP surgery, or in accident and medical or after-hours clinic. There is much discussion on trying to get patients to go to the "right" place. Until the patients are seen and fully assessed by a doctor, it may not be possible to reliably decide on what needs to be done, and where and by whom (and even after they are seen, it may not always be clear cut). It is well recognised that assessment/triage to prioritise a patient's care within a facility is different to that needed to send them away to another facility (Ref. 8) and to do so safely requires a lot more time, effort, and resources. Even Healthline (Ref. 6) will not always recommend patients go to the correct facility when compared to their final diagnosis — but this is because it appropriately has a cautious approach to try and avoid patient harm. In many situations around New Zealand, there may only be the

choice of one or two health providers — local doctor/nurse and/or ambulance service being a common situation.

From my experience, most members of the public get the initial decision of who to see right most, but not all of the time.

Another consideration when thinking about triage, both before arrival at a health care facility and triage after arrival, is the concept of "barriers" to health care. Barriers to care include cost of service, physical access to services (e.g. transport availability and cost), waiting times (both to get an appointment, and the wait to be seen once at the health facility), knowledge of when to be seen or not for a particular illness and knowledge about self-care, and perceived reactions of health professionals to the presentation — for example some patients are concerned that doctors will be upset if they come in too early or too late for any given illness — and paradoxically the longer they wait the less likely they are to want to come in, or sometimes they are worried the doctor will think they are a "hypochondriac" — these are all complex issues and can include the influence of past experience(s) with doctors. My own personal experience with a couple of significant illnesses tells me that even with a lot of medical knowledge, it is fairly easy to seek medical attention both too early and too late, both initially and with subsequent visits for the same health problem. The other point here is that I am not trying to say it is the patients or relatives at "fault" — but rather that complex issues occur. For example, if every time you seek medical attention you have to go to a clinic or emergency department and wait for hours it is likely that you will think twice about going back the next time — it may be that the health system has to come up with better alternatives than the currently available forms of health care (this would need careful research and piloting to avoid making things worse) and ultimately we may have to find ways of getting around the current problem of a shortage of both doctors and nurses.

One danger is that we divert doctors and/or nurses into providing triage services when it is probably more efficient just to get on and see the patients in a timely manner — triage may in most situations have a slight chance of improving the outcome of one or two patients but may cause overall harm through inefficiency of use of scarce health professional resources.

Having discussed briefly the complexities of the decision about when and where to get seen, it should be apparent that many delays can occur before the patient arrives at the clinic — these may often outweigh the delay that occurs once they arrive at the health facility. However once the patient arrives at a health facility there is clearly some responsibility for the health facility and its staff to treat patients in a timely manner. Decisions about this usually refer to the concept of "triage". It may be that the type of patients that present at a health facility mean that triage is usually not necessary but at just about any health facility, an emergency case can arise and there should be some method of dealing with this. If there is regularly the possibility of a wait beyond a reasonably safe period of time for the type of conditions that present to a health care facility then formal triage may well be required — but deciding as to if

this is the case is not clear cut. Which system of triage is best in which facility and at which times is not a simple thing to decide upon. These issues will be discussed in the next section.

**Triage Issues**

"Triage" has various definitions but a reasonable one is "the sorting of patients based on the need for treatment and the available resources to provide that treatment" (Ref 7). As a result of triage, patients may be seen straight away or wait for some time depending on what the triage process suggested was their level of urgency and depending on what resources (nurses and doctors) are available. Whilst it may seem like a good idea that triage should always occur, it may not be a good idea or it may have to be applied in a different manner for a number of reasons including:

- If there is no waiting time to see a doctor, it is not really needed and/or it may cause further delays.

- If all the patients are likely to not be emergencies, it is probably best to get on and see them rather than diverting resources to "triage" when they could be used instead to see people more thoroughly and finish the job. For example, in an accident and medical clinic it is likely that more urgent cases have either called ambulances and been taken to the local hospital emergency department or that they have gone there directly themselves.

- It may increase the overall resource needed to see patients and not actually improve overall patient care — you may need extra staff and or rooms and equipment to do the triage. This can have adverse consequences including cost of the service to the patient, increased waiting time for some patients and subsequent reluctance of patients to re-attend for the same or a different problem in future.

- Nurses and doctors are trained to see people in a thorough manner (for example taking histories and examining patients in some detail and ordering tests when necessary to come up with a likely final diagnosis and treatment plan) and asking them to change and assess patients in a rapid manner for a different purpose is problematic and requires different special training.

- Triage may have to be different in different situations — for example if there are multiple casualties (where the number of patients and the severity of their conditions do not exceed the ability of the facility to render care), there is a different approach to triage than when there are "Mass Casualties" where the patients and the severity of their conditions do exceed the capability of the facility and staff.

It may well be a reasonable assumption that patients who present to New Zealand accident and medical clinics and general practice facilities are patients who have decided not to go to an emergency department, and not to call an ambulance, and that triage may not usually be needed. It may be that simple questions at reception or

posters on the wall advising patients that if they have an urgent health problem, they should bring it to the staff's attention rather than simply waiting in turn to be seen — we need more research and evidence to make decisions about this. It may also be that the way "triage" is done after the patient arrives in each facility depends on local issues such as availability of other services and historical patterns of patient behaviour — some clinics may need formal triage and others may not.

It is problematic to decide what is the best way to see patients and what type of triage if any should occur. Most of the evidence on triage is based on studying patients in emergency departments attached to or within public hospitals, rather than in accident and medical or after hours clinics that are separate to hospitals — however some of the evidence is likely to be applicable to such clinics. For example, patients who walk into emergency departments are more likely to be similar to accident and medical or after hours clinic type patients than those who are taken to emergency departments by ambulance.

In emergency departments, the way triage works for patients who walk in is under extensive review. For example, instead of having all patients who walk into emergency departments being seen at the triage area first, if they are directed to reception first, more timely patient flow occurs, there is less confusion, and it is also safe provided delays at reception are not more than 15 minutes (Ref. 1). There are other advantages to being seen at reception first such as the paperwork and administration generally being sorted out (flow on benefits for patients and also more efficient use of health staff such as doctors and nurses who subsequently see the patients — it can be a waste of nursing resource for them to do the initial clerking of the patient at triage for example). Also, patients have reported to me that they prefer being seen at reception first from their experience as this gives them more "psychological relief" (patients' words not mine) than having to wait in a triage queue ([queues] do occur at triage when the triage system is overloaded). It may be that the best system is that when a "queue" exists at triage, that the receptionist sees and clerks patients before they join the triage "queue" (this would apply for walk-in patients rather than patients brought in by ambulance).

Another approach is to try and see patients first at the time they would have been at triage (i.e. see them straight away rather than "triaging" them). This is instead of using the same staff that would have been used later on after patients had been triaged (Ref. 2). This approach found that by using a senior clinical team (an experienced senior doctor and an experienced senior nurse) for initial patient consultation, the numbers of patients waiting fell dramatically throughout the ED. This suggests that taking staff away from seeing patients after they have been triaged, and instead getting them to see patients as they are triaged (or instead of triaging them) may be a more effective use of staff resources and benefit all patients in terms of waiting time. A New Zealand study along similar lines that controlled for overall staffing levels showed that the rapid management of patients with problems which do not require prolonged assessment or decision making, is beneficial not only to those patients, but also to other patients sharing the same, limited resources (Ref 5).

Even if triage does take place, there is then a further problem of trying to get the triage "correct". Triage is problematic in that patients can be prioritised as too urgent or not urgent enough compared with what more full medical assessment finally shows. This problem of under or over "triaging" can lead to direct consequence for the individual patient if under triaged (being made to wait too long) or indirect consequences to other patients who might be made to wait longer because the patient was 'over' triaged. These consequences in the case of being made to wait can be serious including death (Ref. 10, 11).

Telephone triage attempts to have standardised computer aided systems of triage do not necessarily overcome this problem — a comparison of different systems showed there were large differences in outcome between nurses using different software systems to triage patients (Ref. 3). Some of these problems just end up being accepted (it is generally accepted that it is safer to send a few patients unnecessarily to urgent medical care than to miss an urgent patient and tell them to wait for less urgent care). Studies have been done to show that the current NZ Healthline type phone advice system is safe (Ref 4). Healthline is useful for patients where they can not get in touch with their own GP in a timely manner (for example after hours). What we do not know is if they should use Healthline when they can get hold of their own GP. It is possible that their own GP who has the advantage of knowing the patient and/or access to their medical record could "triage" phone calls better than Healthline but we can not be sure about this at present. What is now needed are a number of good research studies to show what, if any triage, systems should be used outside of hospital emergency departments, and outside of phone call advice considering both when usual health care providers are available and not available. Similar research also needs to be done for triage occurring at health care facilities that are not emergency departments as well as those that are emergency departments.

When patients turn up at GP surgeries, or at after-hours surgeries, or at accident and medical clinics with apparently urgent problems, there may need to be systems to deal with the problems in a timely manner. If such problems are rare then common sense may be enough — for example if a serious injury occurs just outside the facility then the duty of care overrides the care of booked-in or routine patients and the facility will direct doctors and nurses to the patient(s) providing care until it is clear that either the facility can deal with the patient, or they can be sent elsewhere or an ambulance arrives etc. **It is not clear if receptionists can recognise patients ultimately triaged to emergency categories (or diagnosed as an emergency) but it seems likely for walk in patients that harm is unlikely to occur from having them see patients first (Ref. 1).**

It may be that the best approach is to only triage walk-in patients who state their problem is urgent — but we need good research on this topic. At present this approach is reasonably common in accident and medical clinics and after-hours clinics around New Zealand. It occurs every day in general practice when patients either phone general practice surgeries or walk in and ask for appointments. Thus, it is

established practice and to change this needs great care. The health system would become overloaded if every appointment was required to be triaged by nurses for example. For patients who do not state their problem is urgent, it is reasonable for them to wait in the manner that is usual for the health care facility concerned. Some approaches taken for bringing it to a patient's attention that they need to tell staff if they have an urgent problem such as chest pain, or they are very unwell, include having large signs up at reception and in the waiting area advising them of this fact. It is not reasonable or appropriate in many of the health care facilities to triage everyone — there are many reasons including:

- Staff could be better used doing tasks other than triage.
- Lack of physical space for triage to occur and risks of breach of privacy — some patients may not want to tell another person (nurse at triage) about their condition (e.g. sexually transmitted infection) and just want to see a doctor, some facilities may not be able to have a confidential area for triage without using up a room that is already used at busy times for seeing patients.
- Staff trained in triage may not be available.
- Staff trained in triage may have been trained for triage that is appropriate in one setting (e.g. emergency departments) that is not necessarily appropriate in another setting (in accident and medical or after-hours clinics).
- As already discussed it may worsen overall care for all patients at the time (more overall delay for all patients) and put patients off coming back due to the extra waiting overall.
- It may worsen [a] patient's individual care if the triage is incorrect.
- We may not improve patient outcomes beyond the decision they have already made — in other words, for the few times that patients have come to the wrong place at the wrong time, adding in triage may not actually improve overall care.

**Other approaches**

Waiting times can be addressed by a variety of measures that include better matching of staff to patient workload. It is well recognised that patients attend more between the hours of 10am and 2pm than earlier in the morning for example — staffing rosters can be made to reflect this and help reduce waiting times (Ref 9).

At present, after-hours care is being reviewed nationwide and it is possible if different "rules" or "policy" are applied to emergency departments in terms of access to care for patients with apparently less urgent conditions, that problems could occur and the nature and type of patients presenting at other clinics could change. Also, the funding of care may change which may either increase or decrease the work load of clinics or it might change the type of workload. This may well mean that current or future policies of clinics with respect to staffing arrangements, physical facilities and equipment and triage might have to change.

Second visits for the same problem may need more urgent priority than first visits. I am not aware of any research on this approach. It seems like a good idea but care is required. Other possibilities could include reducing the fee the patient pays for second visits but this is problematic as they often take longer than first visits and take more staff and resources (Ref. 9) and hence cost more. Each clinic would need to review this based on re-attendance rates and types of patient problems involved but it may be [that] this provides a good safety net for doctors giving advice for patients to self monitor their conditions over time — if patients are reluctant to come back because of cost, this could over ride the safety net value of such follow-up advice.

**References**

1 Emerg Med J 2001; 18:441–443; Should ambulant patients be directed to reception or triage first? S Goodacre1, F Morris1, B Tesfayohannes1 and G Sutton2

2 Emerg Med J 2004; 21:537–541 Making an IMPACT on emergency department flow: improving patient processing assisted by consultant at triage; J Terris, P Leman, N O'Connor and R Wood

3 Emerg Med J 2003; 20:289–292; NHS Direct: consistency of triage outcomes; A O'Cathain, E Webber, J Nicholl, J Munro and E Knowles

4 NZMJ Journal of the New Zealand Medical Association, 11 July 2003, Vol 116 No 1177; Giving emergency advice over the telephone: it can be done safely and consistently; Geoffrey Hughes

5 NZMJ Journal of the New Zealand Medical Association, 02 July 2002, Vol 115 No 1157; Effect of a rapid assessment clinic on the waiting time to be seen by a doctor and the time spent in the department, for patients presenting to an urban emergency department: a controlled prospective trial; MW Ardagh, J Elisabeth Wells, Katherine Cooper, Rosa Lyons, Rosemary Patterson, Paul O'Donovan

6 Healthline 0800 611 116; http://www.moh.govt.nz/healthline
Healthline provides:

- an assessment of medical problems with advice on the most appropriate level of treatment and a recommended timeframe for doing so
- advice on self-care and symptom management
- advice on the prevention of illness
- health information, for example information about diseases
- information about availability and location of services
- referral connection to other emergency services

7 Advance Trauma Life Support for Doctors, American College of Surgeons Committee on Trauma, Student Course Manual, 1997, ISBN 1-880696-10-X

8 Triage; http://www.emedicine.com/emerg/topic670.htm#top; Robert Derlet, MD

9 Personal experience with local after-hours clinic and discussion with management.

10 Personal knowledge of a few cases in a local emergency department where patients have been "triaged" to non-urgent and left the department before being seen and subsequently died out of hospital or re-presented at too late a time in the illness for death to be prevented.

11 Part of case summary — "that night she presents to ED, is triaged as non-urgent, and leaves before being assessed. At home, she tragically collapses and dies"; Complaints, hindsight bias, and the short-circuit of grief into grievance; Hamish Wilson, New Zealand Family Physician (NZFP) Volume 32 Number 5, October 2005